Health Home Planning Workgroup
October 30, 2012
AmericInn, Fort Pierre, SD
Meeting Minutes

Members in attendance: Senator Corey Brown, Senator Jean Hunhoff, Senator Deb Peters, Representative Suzy Blake, Representative Scott Munsterman, Dr. Ken Aspaas, Nicole Bartel, Terry Dosch, David Flicek, Jill Franken, Dave Hewett, Lynette Huber, Amy Iversen-Pollreisz, Jill Kruger, Kim Malsam-Rysdon, Rod Marchiando, Kathi Mueller, Barb Smith, and Tony Tiefenthaler

Others in attendance: Sandy Crisp, Ann Schwartz, Leah Ahartz, Shawn Nills, Alan Solano, Jesse Smith, Ruth Krystopolski, Deb Fischer-Clemens and Jean Reed

Members Absent: Dana Darger, Dr. Tad Jacobs, Colleen Winter, Representative Justin Cronin, Deleen Kougl and Sonja Weston

Kim Malsam-Rysdon opened the meeting by updating the workgroup on several discussions DSS staff have had with Centers for Medicaid and Medicare Services (CMS) to discuss South Dakota's Health Home implementation. She thanked the group for their participation and commitment to the Health Home project as stakeholder involvement and input have made for a better process overall. She also reiterated that the workgroup's goal is to support successful ongoing Health Home implementation and not simply a pilot project. For the remainder of the meeting, the workgroup reviewed the meeting objectives, key aspects the workgroup has agreed upon to date and the recommendations of the Implementation subgroup.

Meeting Objectives:

- Review the work of the Implementation subgroup
- Review and discuss implementation scope
- Review prospective cost reporting process
- Discuss overall timeline and next steps

Review of work to date:
The workgroup reviewed key decisions that have been made by the group to date.

Populations: The workgroup reviewed the populations to be eligible for each Health Home. To help structure details specific to the different types of Health Homes, the Department will file a State Plan Amendment specific to Primary Care Health Homes and a second State Plan Amendment specific to Behavioral Health Health Homes.

The populations to be served by the Primary Care Provider Health Home includes Medicaid recipients where the primary diagnosis is two or more of the chronic conditions listed below or one of the chronic conditions listed below and one of the at risk conditions listed below:

- Chronic Conditions include: Asthma, COPD, Diabetes, Heart Disease, Hypertension, Obesity, HIV, Muskoloskeletal and Neck/Back disorders.

- At Risk Conditions include: Pre Diabetes, tobacco use, Cancer, Hypercholesterolemia, Depression, and use of multiple medications (6 or more classes of medications).

The populations to be served by the Behavioral Health Heath Homes are Medicaid recipients where the primary diagnosis is a Severe Mental Illness or Severe Emotional Disturbance and recipients where the primary diagnosis is Substance Abuse.

Provider Infrastructure: The workgroup reviewed the designated provider and team of health care provider options selected for Health Homes in South Dakota.

Details for the provider infrastructure for Primary Care Provider Health Homes include the following:

- Designated providers include a primary care physician (e.g., family practice, internal medicine, pediatrician or OB/GYN) or midlevel practitioner, working in a Federally Qualified Health Center, Rural Health Clinic, or clinic group practice.
- The designated provider is part of a physician led team, supported by a team of health care professionals and support staff that establishes an ongoing relationship with the patient.
- A designated provider team of health care professionals may also include behavioral health providers, a health coach/care coordinator/care manager, chiropractor, pharmacist, support staff, and other services as appropriate and available.
- A health home may include multiple sites identified as a single organization that share policies, procedures and electronic systems.

The group suggested eliminating the reference to a "midlevel practitioner" and replace it with "Advanced Practice Nurses and/or Physician Assistants." The Primary Care Provider Infrastructure documents will be updated to reflect this change.

Details for the provider infrastructure for Behavioral Health Health Homes include the following:

- Designated providers include mental health professionals working in community mental health center or other behavioral health setting.
- A team of health care professionals including a primary care physician or midlevel practitioner and support staff that establishes an ongoing relationship with the patient will support the designated provider.
- A designated provider team of health care professionals may also include a health coach/care coordinator/care manager, chiropractor, pharmacist, support staff, and other services as appropriate and available.
- A health home may include multiple sites identified as a single organization that shares policies, procedures, and electronic systems.

The Behavioral Health Provider Infrastructure documents will be updated to reflect the change from "midlevel practitioner" to "Advanced Practice Nurses and/or Physician Assistants".

Provider Standards: The workgroup briefly reviewed the provider standards established at prior meetings.

Payment: The workgroup reviewed key aspects of how health home payments will be made:

- PMPM will be tiered rather than a flat rate.
- Tiers will be based on the score from the Chronic Illness and Disability Payment System (CDPS).
- A four tier model will be used.

The workgroup was provided case studies for the four-tier model for both Primary Care and Behavioral Health Health Homes. The group discussed the possibility of shared savings between the state and health home providers. The group recognized that baseline data is needed to develop a shared savings model and that shared savings should be considered for implementation at a future time. The State indicated the State Plan Amendment would include information indicating the intent to evaluate the feasibility of implementing a shared savings model in the future.

Core Services: The six Core Services of Health Homes are as follows:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Patient and Family Support
- Referrals to Community and Social Support Service

The workgroup reviewed and finalized the Primary Care and Behavioral Health Core Services definitions.

Outcome Measures:

- Health Homes are required to implement specific measures in the area of Clinical Outcomes, Experience of Care, and Quality of Care.
- The Outcomes subgroup defined measures in each of the three areas that were presented and approved by the workgroup.
- Specific Behavioral Health indicators were developed in conjunction with Behavioral Health Service providers.

Implementation subgroup recommendations:

Various recommendations of the Implementation subgroup were presented to the workgroup for their review and workgroup consensus. On a monthly basis, DSS will review claims from the previous 18 months to identify Health Home eligible recipients. Eligible recipients will be run through CDPS to be assigned to their appropriate tier and remain at that tier level for 6 months. After 6 months, the tier level will be reevaluated.

Attribution process: The recommended Tier 1 Attribution process was described as follows:

- Recipients in tier 1 will not automatically be attributed as CDPS score indicates current system is generally meeting their needs
- Those in tier 1 will be sent a letter notifying them of the following:
    - They are eligible for participation in a Health Home
    - Listing of all Health Homes in their area
    - Benefits of a Health Home
    - Process for participation
- If a tier 1 recipient opts in, DSS will notify the selected Health Home and attribute the individual to the selected Health Home.

- A tier 1 recipient will have 30 days to opt into a Health Home. If they do not, and they are required to be in Managed care, they will be sent a letter notifying them that they are required to pick a PCP and the routine managed care process will be followed.
- Once a tier 1 recipient is sent a letter, they will not be sent another letter unless they move to a higher tier.

The workgroup agreed that if possible existing relationships between recipients and providers should not be disrupted. The letter sent to recipients will suggest that recipients take into consideration existing provider relationships that may be in place when selecting a Health Home.

Next, the workgroup reviewed the recommended attribution process for tiers 2-4. The recommendation was presented as follows:

- If there is a Health Home available in their area, recipients in tiers 2-4 will be attributed to a Health Home
- Recipients in tiers 2 and above will be auto assigned if there is only one Health Home in their area; if there are multiple Health Homes in their area, the recipient will receive a letter notifying them they have 30 days to choose a Health Home or they will be assigned. Auto assignment will mirror current PCP process.
- Recipients have the option to opt out by completing a Health Home opt out form.
- Tier 2-4 recipients have 30 days to opt out of participating in Health Home. If they opt out and are currently required to participate in the Managed Care Program they will then have 30 days to pick a PCP.

The workgroup discussed the auto assignment process for recipients already seeing a PCP Health Home provider and the group agreed that those individuals would be auto assigned to their current provider if they don't select a different health home.

Recipient incentives: The Implementation subgroup also suggested an incentive to encourage recipients to participate in Health Homes. The recommended incentive is to waive the co-pay for services provided by the Health Home designated provider and their team as well as a specialist visit where the recipient may be referred. The workgroup agreed this should be pursued. It was noted that prior to implementing the recommended incentive, DSS would need to perform a fiscal analysis and ensure CMS would approve this.

Disenrollment process: The Implementation subgroup recommended a multi-step disenrollment process to be used in those situations where a Health Home would want to disenroll a member. The recommended disenrollment process was based on a process currently being used by one or more health systems within the state. Concern was expressed that the process seemed cumbersome. However, after some discussion and agreement that the process should be needed in only extreme situations, the recommended process was accepted with several minor notification modifications.

Provider Outreach: DSS will conduct provider outreach through multiple channels to make providers aware of the opportunity to become a Health Home. Channels to be utilized include the DSS provider newsletter, holding stakeholder information sessions, and completing tribal consultation. Additionally, a Health Home web page will be developed. The workgroup suggested that material include a description of the mutual

benefits for physicians and their patients. Also, that as much as possible, materials should indicate that Health Homes are being implemented in a manner consistent with how other payers are managing patients for higher outcomes and greater satisfaction.

Enrollment: Interested providers will complete an application to be enrolled. The application form is being modeled after other state's applications but would specifically address the agreed upon South Dakota Health Home provider standards. All those who meet the requirements of a designated provider and who can meet the provider standards are eligible to apply. Once the application is received, DSS will review the enrollment application to determine if requirements are being met.

Provider education: Once the application is released, DSS will host open forums to review the application process requirements, core services, outcome measures and other Health Home requirements. Following that, DSS will provide education sessions for approved Health Homes. All approved Health Homes will be required to attend an education session. Additional on-going provider educational requirements will be discussed during the implementation phase evaluation process.

Data Requirements: The workgroup agreed that Health Home data to be supplied by DSS to a Health Home includes:

- Monthly recipient attribution data including all new and existing Health Home recipients
- Claims data until Health Information Exchange (HIE) data available
- Pharmacy data (Will not include IHS Rx data)

A couple of members of the workgroup spoke of possibility that the South Dakota Quality Collaborative being implemented by SDAHO and the South Dakota Medical Association could serve as a data repository for interested providers in the future. The state reiterated how it will provide needed data to providers to support Health Homes and that providers are free to use their own mechanisms to store and analyze information.

Reporting: The Implementation subgroup discussed collection, evaluation and frequency of reporting outcome data. The subgroup recommended that the data be reported to DSS every six months. It was clarified that the data being reported will be specific to Health Home recipients and not the provider's entire population.

DSS indicated they would be running baseline reports for established measures. These reports will be run in aggregate for the following measures:

- PMPM costs by tier
- ER visits
- Hospitalizations and readmissions
- Prescription utilization

Implementation Phase Evaluation: Once Health Homes are implemented, DSS will schedule a six month and twelve month review with Health Home sites, which may be on-site. At those evaluation meetings, it will be determined if mid-year meetings are needed for year two of the implementation phase. At the conclusion of the implementation phase, DSS, in conjunction with participating Health Homes, will determine changes that need to be made to the Health Home structure and evaluate effectiveness for future sustainability.

Key considerations moving forward include:

- Implementation phase should allow DSS to determine where health homes are a useful model to manage patients with high health care needs.

- Implementation should have sites in all geographic areas, urban, rural, and frontier.
- Implementation should have coverage in all high health home population areas.
- Implementation should provide opportunities for Provider collaboration/integration.

Health Home locations: The workgroup reviewed those Primary Care and Behavioral Health locations where preliminary interest has been expressed. It was noted there continues to be several high need areas that would not be served by a Health Home given current expected coverage. DSS will continue to explore avenues to address these areas. As the potential volume of Health Home recipients was being reviewed, it was requested that the location distribution be rerun using only tiers 2-4 since tier 1 will not be automatically attributed. These numbers will be rerun and distributed to the workgroup.

PMPM rate setting process: The Implementation subgroup reviewed a draft cost report and provided feedback. Providers will submit a prospective cost report to determine average anticipated Health Home costs. As this process was discussed it was suggested that a conference call be held to allow finance staff from the respective organizations to participate and get questions addressed. It was agreed that DSS would schedule a conference call as requested. Prospective Health Home PMPM rates will be evaluated against actual costs once Health Homes are operational so that they can be adjusted if necessary.

Kathi Mueller provided the workgroup with an overall project timeline. She indicated that DSS has begun initial meetings on the State Plan Amendments and that because of the strong stakeholder process that has been used, the meetings are going well. It is anticipated that one or both of the SPA's will be submitted in January with an implementation target of April 1, 2013. She explained that if implementation does not occur April 1, it would move to July 1, 2013 as it is important to start implementation at the beginning of a quarter.

Immediate next steps were reviewed. The workgroup was thanked for their participation up to this point and for their willingness to stay engaged in the process. Future meetings will be scheduled on an as needed basis.